

RURAL HEALTH CARE PROVIDER INTERVIEWS:

Developing a Strong Rural Health Care Infrastructure – Challenges and Successes

Prepared by

**Arizona Health Care Cost Containment
System Administration**

October 2002

*Funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration
(Grant NO.6 P09 OA 0001-01 R1) and by the St. Luke's Charitable Health Trust
(St Luke's Technical Assistance Grant NO.2006828)*

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
INTRODUCTION.....	4
STUDY APPROACH AND STUDY POPULATION	6
METHODOLOGY	6
DESCRIPTION OF INTERVIEWEES	7
PROJECT FINDINGS	9
TYPES OF PRACTITIONERS LACKING IN RURAL COMMUNITIES	9
RECRUITMENT AND RETENTION ISSUES	12
RURAL PRACTITIONERS RECRUITMENT STRATEGIES	13
STRATEGIES TO SUPPORT AND EXTEND PRODUCTIVITY OF RURAL PROVIDERS	18
OTHER BARRIERS TO ACCESSING HEALTH CARE.....	21
EFFECTIVE HEALTH CARE COVERAGE STRATEGIES AND PROVIDER PARTICIPATION.....	25
NEEDED LEGISLATIVE ACTION	26
ISSUES HEALTH PLANS NEED TO ADDRESS.....	30
CHARACTERISTICS OF RURAL PROVIDER PRACTICES.....	32
NEXT STEPS	35
CONCLUSIONS	37
APPENDICES	38
APPENDIX A: LIST OF INTERVIEWEES	38
APPENDIX B: MAP OF INTERVIEWEES LOCATION	41
APPENDIX C: SAMPLE LETTER TO POTENTIAL INTERVIEWEE	42
APPENDIX D: RURAL PROVIDER INTERVIEW QUESTIONNAIRE.....	43
APPENDIX E: MAP OF REFERRAL PATTERNS.....	46

EXECUTIVE SUMMARY

As part of a State initiative to develop a plan for providing Arizonans with affordable, accessible health insurance, the Arizona Health Care Cost Containment System Administration (AHCCCSA) undertook a qualitative data gathering effort to better understand the issues faced by rural practitioners and to ensure the implementation of effective strategies for enhancing the rural provider network. This study involving key stakeholder interviews was propelled by the recognition that any efforts to enhance the availability of coverage would be ineffectual if improvements were not made to the rural health care infrastructure including increasing the accessibility to health care providers. Funding for this study was made possible through a U.S. Department of Health and Human Services, Health Resources and Services Administration, State Planning Grant and a St. Luke's Technical Assistance Grant.

Using a standardized questionnaire, AHCCCSA conducted interviews with rural health care providers throughout the State during the months of April through June. Over 90 individuals representing rural practitioners, hospitals and Community Health Centers were interviewed either face-to-face or over the telephone.

Project Findings

The findings from this study reinforce the importance of looking at strategies for improving the rural health care infrastructure in concert with the development of an accessible and affordable statewide health care system. Some of the key findings from the project are highlighted below:

- The majority of interviewees identified the need for both primary care physicians, especially family practitioners in the smaller towns and additional specialists, particularly general surgeons and endocrinologists.
- Communities were also having difficulties recruiting other types of practitioners, especially nurses, laboratory and radiology technicians, dentists, and pharmacists.
- Other mitigating factors (e.g., closed panels, seasonal fluctuations in patient loads, and limited local health plan provider networks) were noted as limiting the provider “accessibility” and thereby contributing to the need for more providers.
- Difficulties in recruiting providers were primarily attributed to the very nature of the rural environment (e.g., lack of amenities, poor schools, professional isolation) with other contributing factors such as low compensation and heavy practice demands.
- An array of strategies was identified which were used to recruit rural practitioners, key ones included:
 - Loan repayment or J-1 visa waiver programs in designated underserved areas.
 - Hospital income guarantee/financial assistance programs.
 - Paying of competitive salaries and offering good benefit packages.
 - Scholarship programs including both student loan programs as well as rural provider sponsored scholarship programs for their own employees.

- Targeting individuals graduating from local health professional programs or those participating in residency or clinical rotation programs.
- Instead of recruiting full time doctors, many smaller communities relied on a network of visiting specialty physicians from the larger metropolitan areas.
- Hospitals and Community Health Centers placed a heavy emphasis on the need to focus their efforts on the retention of current practitioners through the creation of a positive work environment (e.g., incentive plans, work hours, training opportunities).
- Physician extenders (i.e., nurse practitioners and physician assistants) were widely recognized as a valuable component of the rural health care delivery system and were extensively used by practitioners. However, it was felt there was a limit as to how much support these extenders can provide as they increase the physicians' paperwork load and volume of patient calls.
- Telemedicine was predominately being used by hospitals and Community Health Centers in the area of radiology with psychiatry and dermatology being the next most common areas of identified use. Only a small group of interviewees enthusiastically supported its use, while the majority either had serious reservations about its benefits or were unfamiliar with how it could be used.
- In addition to the lack of rural practitioners, other barriers to accessing health care in rural areas included: lack of health care coverage, lack of transportation, overcrowded emergency rooms, limited bed availability in urban hospitals and patient's lack of understanding about the health care system and their own health care needs.
- There was no consistency in terms of which coverage plans providers liked or disliked, (e.g., AHCCCS, Medicare, commercial plans) with reimbursement rates and the "hassle" factor being the key drivers in determining whether they would contract with a particular plan.
- While a wide range of suggestions were offered with regard to issues and/or action steps the State Legislature could take to address rural infrastructure issues, three consistent themes emerged:
 - Control the increasing malpractice rates through tort reform.
 - Provide incentives for physicians to practice in rural environments.
 - Continue allocating Tobacco Tax monies for primary care services.
- Practitioners felt health plans could improve providers' ability to deliver health care to their patients by:
 - Reducing the paperwork demands and streamlining the administrative requirements.
 - Expediting the prior authorization process at the same time minimizing the need for prior authorizations.
 - Streamlining the credentialing process.
 - Reconsidering the rates paid to rural practitioners and ensuring timely and prompt payments of claims.
 - Improving overall health plan operations in areas such as customer service, contracting, and patient management.

- Other than the Community Health Centers, only a limited number of physicians accepted all coverage types, with many limiting or not accepting AHCCCS, and or Medicare patients or members from specific health plans.
- Capacity was currently an issue for many of the interviewees - physicians, Community Health Centers and hospitals especially in their emergency rooms. Other than those planning on retiring, most practitioners felt their patient loads would continue to increase over the next two (2) years.
- To address patient growth a number of the providers were actively recruiting for additional practitioners. Additionally, the Community Health Centers were all planning to expand their access sites and/or add additional services such as dental, behavioral health and pharmacy. Many of the local hospitals had or were in the process of both renovations and/or expanding their facilities.

Next Steps

As a result of the information obtained through these interviews AHCCCSA plans over the next several months to:

- Provide copies of the project report to each interviewee and meet with other key stakeholder groups to provide an overview of the project findings as well as to discuss specific issues that were raised, which involve them in some capacity.
- Provide project findings and any specific policy recommendations to the Legislature (i.e., Statewide Health Care System Task Force and the Rural Physician Study Committee).
- Research and resolve specific AHCCCS related issues which were identified by the interviewees in the areas of eligibility, reimbursement, provider network and overall health plan operations.
- Discuss with responsible entities further research which might be conducted on specific issues (e.g., limitations related to practitioner licensing requirements, improvements to the J-1 visa waiver and loan repayment programs) the results of which could lead to improvements in the rural health care infrastructure in Arizona.

From this study, and additional research and analysis, it is hoped that the State of Arizona will be able to implement effective strategies that address the needs of the rural communities by building stronger rural health care infrastructures and improving the accessibility and affordability of health care for the rural residents.

INTRODUCTION

In March 2001, the Arizona Health Care Cost Containment System Administration (AHCCCSA) received a \$1.16 million dollar State Planning Grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) to develop strategies for providing health care coverage to uninsured Arizonans. This grant was used to assist and support the efforts of the legislatively sponsored Statewide Health Care Insurance Plan Task Force, which was charged with the development of a plan for providing Arizonans with affordable, accessible health insurance.

Given the rural nature of the State it is not surprising that the rural uninsured especially, rural low-income uninsured children and their parents were identified as a key uninsured sub-population in Arizona.¹ However, it was also recognized that if adequate accessibility to health services were not addressed at the same time as availability of coverage, expanding coverage options would have little impact in resolving the lack of health care coverage in rural areas. Therefore, one of the focus areas of both the State Planning Grant and the Task Force was rural health care infrastructure development. As part of the State Planning Grant, AHCCCSA was able to examine initiatives that other states had implemented to enhance access to rural health care services and compile an inventory of strategies that are currently being employed in the State of Arizona.² These strategies were grouped into four (4) general categories:

- Increasing the number of rural practitioners
- Minimizing geographic isolation
- Improving viability of health care facilities including hospital solvency
- Supporting financially rural-based health care service program

In their final report to the Legislature and Governor in December 2001, the Statewide Health Care Insurance Plan Task Force recommended that improvement in rural health care infrastructure needs to be accomplished through a variety of strategies from continuing to support safety-net providers to the development of a plan to more effectively coordinate current health care resources and programs. The ongoing responsibility for addressing this issue will fall upon the newly established Statewide Health Care System Task Force, which has been charged with the responsibility of continuing the efforts of the initial Statewide Health Care Insurance Plan Task Force.

Although the State of Arizona has in place a number of strategies to address the issue of rural health care infrastructure, there appears to be an apparent need to improve upon their effectiveness. In addition, there is a growing concern in the State with regard to the lack of rural providers as well as their reluctance to contract and/or participate with commercial or Medicaid insurers.

¹ "Initiatives to Improve Access to Rural Health Care Services: A Briefing Paper", William M. Mercer, Inc., July 2001

² "Inventory of Arizona Strategies To Address Rural Health Care Infrastructure", Arizona Health Care Cost Containment System Administration, October 2001

In order to better understand the issues faced by rural practitioners and to ensure the implementation of effective strategies for enhancing the rural provider network, it was felt that more diagnostic work should be conducted through a qualitative data gathering effort. With the support of the HRSA State Planning Grant and a St. Luke's Health Initiative grant, AHCCCSA conducted interviews with rural health care practitioners throughout the State. These in-depth key stakeholder interviews were primarily conducted during the months of April through June; soliciting providers' input on both the barriers that discourage practitioners from practicing in rural areas as well as effective strategies for further developing the rural provider infrastructure in the State.

The purpose of this report is to provide a summary of the rural provider interview project conducted by AHCCCSA. The report has been divided into four (4) sections:

- Study Methodology, which provides an overview of the project approach.
- Project Findings, which provides a summary of the key findings and emerging themes both on a statewide basis as well as by community/region and type of provider.
- Next Steps, which sets forth some recommended action steps AHCCCSA plans to take as a result of this study to further explore and develop strategies, which will enhance the rural health care infrastructure in the State.
- Conclusions, which offers some closing observations and remarks.

STUDY APPROACH AND STUDY POPULATION

Methodology

The AHCCCSA HRSA Project Team developed the questionnaire. The initial draft was sent out to various members from the Statewide Health Care Insurance Plan Task Force for review and comment. Based on feedback from some of the early interviewees, some additional minor adjustments were made in the wording of the questionnaire.

In selecting practitioners to be interviewed, the goal was to interview practitioners from all areas of rural Arizona (i.e., communities outside of the Phoenix and Tucson metropolitan areas). The targeted population were physicians both primary care and specialists, and Community Health Centers. Hospital interviews were generally limited to those in areas of the State where on-site visits were being conducted. Assistance in identifying key providers in the area was obtained from members of the Statewide Health Care Insurance Plan Task Force, the Arizona Association of Community Health Centers (AACHC), Arizona Medical Association (ArMA) and Arizona Osteopathic Medical Association (AOMA). The initial list consisted of over 100 practitioners and/or facilities to potentially interview.

Once the list of possible interviewees had been identified, letters were sent out to the individual practitioners explaining the project and informing them that AHCCCSA would be contacting them to see about setting up an interview. The letters to the physicians were sent by the AHCCCSA Medical Director and the letters to the Community Health Centers and hospitals were sent by the AHCCCSA Director. In addition, ArMA, AOMA and AACHC sent out letters to their selected association members encouraging participation in the project. Finally, AHCCCSA sent a letter out to those Legislators whose districts included the communities in which on-site interviews would be conducted so that they would be aware of the study and its purpose.

The interviews were conducted either face-to-face or over the telephone. On-site interviews consisted of both meetings with individual practitioners as well as organized group meetings with physicians. Generally the latter involved 5 to 10 physicians and were held over the dinner hour. The on-site interviews, which targeted key rural service areas around the State, included the following communities:

- Flagstaff
- Sierra Vista and Benson
- Prescott
- Show Low
- Yuma and Somerton
- Salome, Parker, Lake Havasu City, Bullhead City and Kingman
- Globe, Safford and Morenci

Telephone interviews were done when either the individual was not available when the site visits were scheduled in their area or the individual was located in an area, which was not scheduled

for an on-site visit. In addition to some of the communities listed above (i.e., Flagstaff, Prescott, Yuma and Show Low), telephone interviews were also completed with providers residing in:

- Casa Grande
- Surprise
- Ajo
- Willcox
- Elfrida
- Green Valley
- Marana
- Nogales
- Page
- Navajo Reservation (Ganado, Chinle and Tuba City)
- St. Johns
- Payson

Most interviews lasted approximately an hour with the physician group meetings generally lasting two hours. Prior to the interview, a call was made to remind the practitioner(s) about the scheduled interview. Additionally, a copy of the questionnaire was faxed to each interviewee. This proved to be very helpful as many of the interviewees reviewed the questions ahead of time with some even preparing formal responses. Members of the AHCCCSA HRSA Project Team conducted the interviews. The AHCCCSA Medical Director facilitated the physician group meetings. The AHCCCSA Director also assisted with several of the interviews. In addition, at some of the on-site physician group meetings members from the Statewide Health Care Insurance Plan Task Force attended the meeting.

Description of Interviewees

Invitations were made to 134 individual practitioners, hospitals, and community health centers throughout rural Arizona. Of the 134 individuals, 99 (74%) participated either face-to-face, by telephone, or in writing. A total of 53 interviews were conducted: 22 individual on-site, 7 group on-site, 21 telephone, and 3 written interviews. Responses came from all of Arizona's 15 counties. Following is a breakdown of which rural areas the interviews represented (see Appendix A for a list of interviewees and Appendix B for a map of where they are located):

- 2 from Central Arizona
- 14 from Southern Arizona
- 9 from Northern Arizona
- 10 from North Central Arizona
- 17 from Western Arizona
- 1 representing Rural Arizona In General

Below is a breakdown of the types of providers involved (see Appendix A for a detailed list):

- 13 Hospitals (many of which operate satellite clinics)
- 13 Health Centers (many of which are a satellite clinic or operate satellite clinics)
- 64 Physicians (from individual and group interviews)
- 6 Other Individuals/Organizations (which includes 3 physicians)

Of the 27 rural hospitals in Arizona, 13 (48%) were interviewed.

Of the 67 physicians interviewed, 56 (84%) are MDs and 11 (16%) are DOs. Furthermore, within this group were 31 Primary Care Physicians (19 Family Practitioners, 4 General Practitioners, 4 Internists, and 5 Pediatricians) and 35 Specialists.

Those listed under “Other” had unique characteristics and include: 2 Indian Health Services physicians, the Navajo Health Foundation, a Chamber of Commerce, a past President of the Rural Health Association, and a Physician Assistant.

PROJECT FINDINGS

This section provides a summary and analysis of the study findings from the rural provider interviews. Despite a wide range of responses to the interview questions, there were some very consistent responses offered by providers throughout the State. Individual interviewee responses are highlighted along with the common themes that emerged. Additionally, differences are noted when they appear to be linked to factors such as, the size and location of the community (e.g., distance from metropolitan center) and/or the type of provider (e.g., hospital, Community Health Center, physician).

This discussion has been grouped into the following categories, which generally mirror the questionnaire:

- Types of practitioners lacking in rural communities.
- Reasons why it is difficult to recruit practitioners and/or why they leave rural communities.
- Strategies used to recruit rural practitioners.
- Strategies to support rural providers and extend their productivity.
- Other barriers to accessing health care in rural areas and strategies employed to address these barriers.
- Effective health care coverage strategies and provider participation in coverage options.
- Needed legislative action to address rural infrastructure issues.
- Health plan action to improve the delivery of health care by rural practitioners.
- Characteristics of current rural provider practices.

Given this study employed a qualitative data gathering methodology in which interviewees were not drawn from a statistically representative sample one needs to be cautious in the interpretation of the results and not assume that generalizations drawn from this study “statistically” represent all rural providers. The information, however, is based on responses from over 90 practitioners and hospital and Community Health Center representatives and does provide the reader with a great deal of insight into rural practitioner issues and concerns and potential strategies that might be implemented to improve rural health infrastructure.

Types of Practitioners Lacking in Rural Communities

Primary Care Physicians

The majority of interviewees identified the need for more primary care physicians (i.e., “generalists”) in their community, especially in the smaller towns (e.g., St. John, Eloy, Young, and Bouse). In particular, family practitioners were seen as lacking with fewer interviewees citing a need for internists and/or pediatricians. While only a few providers felt there was a need for more obstetricians in their communities, concern was expressed that the need for obstetricians could become more acute in the future due to the increasing malpractice rates which

is causing many family practitioners to cease providing obstetrical services and obstetricians to cease practicing all together.

Specialists

The interviewees also felt there was a need for additional specialists in their communities. General surgeons and endocrinologists were most frequently cited as lacking. Other types of specialists that were identified as being needed in communities included:

- Rheumatologists
- Pulmonologists
- Radiologists
- Cardiologists
- Orthopedists
- Anesthesiologists
- Neurologists
- Neurosurgeons as well as other specialty surgeons (e.g., cardiothoracic, plastic)
- Psychiatrists
- Gastroenterologists

In a number of cases, the issue was not that a full time specialist was needed in the community as much as visiting specialists (i.e., “circuit riding docs”) needed to come more frequently (e.g., Globe needed the rheumatologist to come more frequently than three (3) or four (4) times a month).

Other Practitioners

Not surprising, given the State as well as national trends, almost all the interviewees said they were experiencing a lack of nurses (RNs). This was of special concern at the local community hospitals where it was felt this shortage impacted both bed availability and the capacity to perform operations and deliveries. The hospitals also expressed concern about the growing lack of technicians in all specialty areas (i.e., radiology, ultrasound, and laboratory). With a few exceptions, recruitment of physician extenders (i.e., nurse practitioners (NPs) and physician assistants (PAs)) did not appear to be a problem. Other health care practitioners that interviewees felt were needed in their communities included:

- Pharmacists to staff hospital and clinic pharmacies. One interviewee linked the unavailability of pharmacists to the fact “Walgreen’s has a goal of hiring 100% of the 2002 graduating class of pharmacists in the nation”. Some smaller communities also lacked an actual “pharmacy”.
- Dentists, especially those who are willing to serve uninsured low-income or Medicaid eligible individuals
- Respiratory therapists
- Behavioral health practitioners

- Licensed practical nurses (LPNs)
- Certified medical assistants

Additional Observations

In identifying the specific type of providers needed in the communities, interviewees offered some general observation regarding the “lack” of providers in the community. Many interviewees pointed out that if one only looked at the actual number of providers in the community it might appear that there were enough providers to care for the residents in the community. However, a more in-depth analysis would reveal other mitigating factors, which limited “accessibility” to these providers. Examples of such factors included:

- Unwillingness of some physicians (and dentists) to see AHCCCS patients and uninsured individuals (self-pay).
- Heavy patient loads that result in long appointment wait times or closed physician panels (e.g., AHCCCS members in Safford being assigned to physicians in Morenci because Safford physicians were not accepting new AHCCCS members).
- Quality of care concerns surrounding certain physicians in the community.
- Seasonal fluctuations in population which overload and limit the accessibility of physicians especially primary care physicians during these periods, (e.g., Yuma in the winter, Show Low in the summer).
- Insurers with limited local provider networks so as one interviewee stated “having insurance is not the same as having a place to get care.”

Interviewees also noted that there are often differences in what the community perceives as being needed vs. what is realistic and can be “financially” supported in their smaller communities. For example, Salome recognizes that as a town of 2,200 permanent residents it is simply not feasible to have an urgent care center or numerous specialists available at all times and thus has concentrated their efforts on arranging for primary care services to be available in their community. However, other communities were pointed to, which want to see 24-hour health care services made available even though these communities can barely support a 9-to-5 health care system, five (5) days a week.

Lastly, interviewees also stressed that while a physician may be very busy (or perceive him/herself as being busy) there needs to be enough unmet need in the community for another physician to have an economically viable practice. This issue gets more complicated by the fact some residents lack faith in their local health care system and as such seek care outside of the community in the larger towns or metropolitan areas. Several examples were given of residents who felt uncomfortable going to the foreign J-1 visa waiver physicians located in their community.

Recruitment and Retention Issues

The interviewees cited the very nature of the rural environment itself as the primary reason for it being hard to both recruit and retain practitioners. Specific aspects of the rural environment that were noted included:

- Unwillingness of the spouse to live in a small community and/or inability for the spouse to find a job.
- Lack of amenities (e.g., limited shopping, entertainment and/or availability of desired ethnic foods).
- Poor climate (e.g., heat, snow).
- Remoteness (e.g., long distances to larger metropolitan and limited and expensive air service).
- Poor schools with limited opportunities to take higher education classes.
- Limited housing.
- High cost of living.
- Professional isolation with limited “technical support and equipment”.
- Closed community both in terms of other medical providers and cultural/ethnic biases.

Everyone agreed it takes a special kind of person to practice in these rural communities, especially the more remote settings. Interviewees noted that practitioners, especially if their spouses have rural roots, are drawn to small rural communities and are the ones who are more likely to end up staying long term. Additionally, persons who like the outdoors, e.g., hunting, fishing, hiking will be more likely to move to places like Show Low or Flagstaff and those who are service oriented are more willing to take jobs with the Community Health Centers or the Indian Health Service. Finally, interviewees felt it was easier to recruit physicians to communities, which are medium size towns (e.g., Flagstaff, Yuma) or are close to large metropolitan areas (e.g., Green Valley, Casa Grande) because they provide the physicians with the option to live in the urban setting and commute to the rural community.

In addition to the rural environment, other reasons why interviewees felt it was difficult to recruit practitioners to the rural communities included:

- Compensation. Some interviewees felt that it was more difficult to make a living in the rural environment due to the payor mix (i.e., high number of uninsured and/or AHCCCS members), low payment rates for rural health care services and continual increasing malpractice costs. Some of the publicly supported clinics (e.g., Community Health Centers, Indian Health Service clinics) noted it was difficult for them to offer competitive compensation packages.
- Practice Demands. The demands placed on physicians practicing in a rural environment also were noted as deterrents. Physicians, especially in the more remote communities, are expected to be “jack of all trades” and to be willing to do everything including tasks, which traditionally might be performed by an RN or medical assistant. Numerous interviewees felt the lack of back-up and the necessity to be on-call frequently were key barriers to recruiting rural practitioners as well as led to the eventual burn-out of those rural providers who enjoyed living in the rural environment. Additionally, there is less of

an ability to escape one's work as one may continually run into patients outside of the office settings.

- Lack of Available Practitioners. In a broader context, several interviewees felt the problem of recruiting rural practitioners is made more difficult simply by the fact there is a growing lack of practitioners on a national level.

Some of the same reasons why it is difficult to recruit practitioners to rural communities were also noted as reasons for why practitioners decide to leave (e.g., compensation, nature of rural environment, on-call demands). In addition, other reasons noted included: personal reasons (e.g., divorce, need to be closer to family), service obligation is completed as part of a recruitment program (e.g., loan repayment, J-1 visa waiver program), no Continuing Medical Education courses, general professional isolation with no ability to function at a higher level of proficiency, limited opportunities for career advancement and/or an unpleasant work environment.

Rural Practitioners Recruitment Strategies

The interviewees identified a number of recruitment strategies. Most of these strategies were being employed by local community hospitals or the Community Health Centers. While only a few of the physicians interviewed had been directly involved in recruiting other physicians into their community they were aware of strategies being used by their local hospital, had actually been recruited themselves, and/or had suggestions to offer as to possible recruitment strategies. Additionally, not all the strategies are applicable to all communities as a number of the “publicly” supported recruitment strategies have program requirements, which restrict eligibility to certain types of designated health shortage areas. Below is provided a description of the recruitment strategies identified by the interviewees; including a discussion of some of the concerns raised.

Loan Repayment

The most commonly cited recruitment strategy was the Federal and State loan repayment programs in which a physician's medical school loan is forgiven in exchange for the provision of two (2) to five (5) years of service in an “under-served area”. The definitions of what areas in the State qualify for these loan repayment programs varied by program (e.g., Medically Underserved Areas (MUAs), Health Professional Shortage Areas (HPSAs)). Additionally, some of the loan repayment programs (e.g., Primary Care Provider Loan Repayment Program) only target primary care physicians while others (e.g., National Health Service Corps) include a broad array of health professionals such as physicians, nurse practitioners, physician assistants, and dentists. Interviewees felt these programs provide a strong incentive to physicians to practice in rural areas given recent graduates are coming out of medical school with over \$100,000 of debt. On the other hand, some concern was expressed that these loan programs do not afford long-term solutions to the shortage of rural practitioners many of whom leave the rural sites as soon as the loan is repaid. Others felt there was not enough money available in these programs or expressed frustration that their particular community (e.g., Flagstaff) did not qualify for these programs.

J-1 Visa Waiver Program

For some of the smaller, more remote rural areas in the State (e.g., Springerville, St. John, Dolan Springs, Parker), the J-1 visa waiver program was viewed as a critical program for the recruitment of physicians into these areas. This program allows foreign physicians, who have completed graduate medical training in the United States to remain in this country after their studies are completed. In addition to federal agencies, the Arizona Department of Health Services (ADHS) is allowed to request up to 20 J-1 visa waivers per year for physicians (2 - 3 of which can be specialists) to work at least three (3) years in designated HPSAs or MUAs. Interviewees expressed concern that this program would not be reauthorized because after 9-11 the United States Department of Agriculture terminated their participation in the program. Sunset Community Health Center which has actively used the J-1 visa waiver program as a recruitment strategy, noted they have also been successful in retaining many of these physicians after their three years of service is completed.

Despite strong support, and good success in recruiting and retaining physicians in some communities, a number of interviewees expressed the following concerns regarding the J-1 visa waiver program:

- “Racial prejudice” in some local communities makes it difficult for these foreign doctors to effectively practice in these communities and /or does not encourage retention.
- Inability of the Indian Health Service to use this program.
- Too much of a “hassle” having tried it once.
- Program requirements which do not allow some rural areas (e.g., Kingman, Globe, Flagstaff, Yuma, Sierra Vista) to qualify for the program and/or do not allow sharing of a physician between two communities in cases in which one community could not support a full-time physician.
- Need for more monitoring of the J-1 visa waiver physicians to ensure that they are employing the required sliding fee scale.

There were mixed feelings expressed regarding the acceptance into the program of physicians who are specialists vs. primary care physicians. One interviewee wanted to be able to bring in more specialists through this program, while another complained about J-1 visa waiver doctors who committed to doing primary care but then proceeded to focus on their specialty areas.

Income Guarantee /Financial Assistance Programs

The use of income guarantee or financial assistance programs was a recruitment strategy utilized by many of the local rural hospitals, which were interviewed. While the local physicians did not always agree on the hospital’s recruitment priorities (e.g., lack of commitment to bringing in more family practitioners), they did see the local hospital, as being instrumental in bringing needed physicians into the community by helping to defray relocation costs and debts. Hospitals “incentive” packages varied from hospital to hospital but elements of these packages might include: guaranteed income for a certain number of years, payment of relocation costs, paying the costs associated with setting up an office with repayment spread over four (4) years, covering

the first year of malpractice to be forgiven over three (3) years. In one community, the physicians expressed concern over the income guarantee program as they felt these new physicians were being guaranteed incomes which were higher than what they were earning and yet these new physicians had no incentive to work hard.

Compensation and Bonuses

A number of the Community Health Centers and local hospitals felt by paying competitive salaries and offering good benefit packages they were able to attract and retain physicians as well as other health care practitioners. A number of the Community Health Centers acknowledged this became more feasible as a strategy as a result of the AHCCCS cost reimbursement settlement. AHCCCS developed a Prospective Payment System (PPS) effective January 1, 2001. The purpose of the PPS is to ensure that a Federally Qualified Health Center's (FQHCs) reasonable costs for providing services to Medicaid recipients are reimbursed. After the PPS was completed, AHCCCS reconciled managed care operation and fee for service payments to Community Health Centers to the amount they would have received under PPS. The difference was reimbursed to the Community Health Centers. Additional reimbursement ensures that they will remain viable and functioning safety net providers. The “take home pay” of physicians hired by the Community Health Centers was also enhanced by the fact they did not have to purchase malpractice insurance, as they would be covered under federal tort law. In addition to competitive salaries, a number of the hospitals were offering signing bonuses. One hospital would adjust these bonuses depending on their staffing needs while another hospital offers the bonuses to current employees who find needed personnel, allowing them the option to split the bonus with the new employee.

One hospital administrator strongly supported the approach of directly hiring the physicians (including internists and family practitioners) as salaried employees of the hospital. By employing this strategy he was able to more readily attract physicians to move into the rural community. This approach also appealed to the physicians as it provided a guaranteed income, let them avoid having to pay high malpractice premiums and provided them with office space, staff and other support services such as assistance with billing.

Finally, some of the individual physicians suggested increasing rural reimbursement rates would also serve as a strong incentive in encouraging physicians to practice in rural areas. “Money works”, one group of physicians noted.

Scholarship Programs

Interviewees identified two (2) types of scholarship programs that are generally used as a means to recruit practitioners. The first type are those scholarship/student loan programs offered to students in health professional fields who in turn commit to practicing between two (2) to four (4) years in underserved areas after graduating. These programs were generally not viewed as effective as the loan repayment program as interviewees felt at the time the students commit, many of them do not really know what they want to do or where they want to practice. And as a

result, many of the practitioners in these scholarship programs immediately leave the rural communities after they complete their service commitment.

The second type of scholarship program, which was viewed as a much more successful strategy focused on “growing your own”. The Community Health Centers as well as the hospitals said they often would pay for their employees to pursue various career advancement opportunities (e.g., LPNs to become RNs, medical assistants to become LPNs) or to attend specialized training programs in areas such as ultra-sound technology, intensive care unit services, and orthodontia. In return for these education/training opportunities, the employees are generally required to make a one (1) to two (2) year commitment to continue to work at the facility. In addition to allowing the Centers and hospitals to fill staff shortage areas, this strategy has also proven effective in decreasing staff turnover. A limiting factor to this approach, is the availability of local educational training opportunities which would allow the trainee to remain in the community while pursuing additional training.

Targeting Specific Pools of Practitioners

A few of the interviewees said they use residency programs and/or clinical rotations as a source for possible candidates to fill the slots for needed health care providers in the community. Examples were provided of hospitals and Community Health Centers serving as training sites for medical students from the University of Arizona and Midwestern University (i.e., an Osteopathic school located in Phoenix) as well as for nurse practitioners or physician assistants doing clinical rotations. As a result of these rotations, facilities have in some cases been able to successfully recruit some of these students.

Some of the local regional hospitals have established residency programs at the hospitals. For example, Kingman Regional Medical Center is looking into establishing an emergency room residency program in addition to the recently established family practice residency program. In addition to local residency programs, the Navajo Foundation, a non-profit corporation with its main clinic in Ganado, successfully recruits residents from dental and family practice programs located all over the United States, while the Tuba City Indian Medical Center, an Indian Health Service facility has staffed half their pediatric program through an established relationship with John Hopkins University Medical School.

Several interviewees said they aggressively recruit individuals who are graduating from the health professional programs at the local community colleges (e.g., RNs, LPNs). For example, Navapache Regional Medical Center in Show Low recruited 20 RNs from the local community college last year. This type of strategy along with the “employee scholarship program” described above were viewed as longer-term solutions since they target local individuals in the local community – individuals who are more likely to stay and work in the local community.

Use of Visiting Physicians

As mentioned earlier in the report, instead of actively recruiting physicians to set up a full time practice in the community, some of the smaller communities (e.g., Show Low, Wilcox, and Tuba City) have enhanced their health care delivery system by arranging for physicians to come to the community to see patients several times a month. Generally, these visiting physicians come from larger metropolitan areas, e.g., Tucson, Phoenix, and Flagstaff. For example, Northern Cochise Community Hospital feels they have been able to meet a wide range of the medical needs in their community through the use of visiting physicians. They currently have 20 to 23 specialists that come to Wilcox at various frequencies per month and who both hold clinics as well as perform necessary surgeries. In Globe, specialty clinics are held several times a month, staffed by physicians from Phoenix or Tucson with specialties in the areas of cardiology, pulmonology, rheumatology, dermatology and oncology. A slightly different model occurs in Show Low where the local cardiologist provides outreach clinics in the surrounding communities, e.g., of Overgaard, Taylor, Snowflake, Winslow and Springerville.

Other Recruitment Strategies and Issues Related to Recruitment

In addition to the key strategies mentioned above, numerous other recruitment strategies were mentioned by the interviewees, including:

- Advertising job openings on professional web sites or depending on word of mouth.
- Establishing a recruitment office at the hospitals.
- Using a recruitment firm, although one physician felt this was a very expensive strategy, which was only minimally successful.
- Redefining the job specifications to make it more appealing, e.g., one Community Health Center only required the pharmacist to work four (4) days a week, no nights, weekends, or holidays.
- Focusing on the retention of experienced hospital staff, minimizing the need to have to recruit (see discussion in next section under “Job and Work Environment”).

The interviewees made a number of suggestions as to steps that could be taken to improve the recruiting environment in the rural areas. One suggestion made by interviewees throughout the State was the need for the University of Arizona Medical School to make a stronger commitment to encouraging students to practice in the rural areas. There was a general feeling expressed among providers that the University is focused only on research and high-end medicine, is academically oriented rather than practice oriented, lacks any rural focus and shows no leadership in promoting rural clinical rotations. Another suggestion was made to change the State statute so specialists who have been practicing in other states do not have to take an exam again if they have been out of school for more than 10 years to practice in Arizona.

Strategies to Support and Extend Productivity of Rural Providers

Given the scarcity of resources in the rural environment rural providers have developed and put into place strategies which both “encourage” the local health professionals to continue to practice in the local rural community as well as extend their overall productivity. A number of the hospitals and Community Health Centers were focusing their efforts on the retention of current practitioners through the creation of a positive work environment. When specifically asked about the use of physician extenders, telemedicine and mobile diagnostic equipment as a means to support and extend provider productivity, interviewees had mixed reactions. However, interviewees did suggest a number of other things, reviewed below, that are being or could be done to enhance the current rural health care infrastructure. Additionally, they identified issues that need to be addressed in order to make this possible.

Physician Extenders

Many of the interviewees saw physician extenders (i.e., NPs and PAs) playing an increasingly important support role in the delivery of effective health care services in rural communities. In addition to being used by individual physician practices and Community Health Centers to handle episodic care, a number of the local hospitals employ physician extenders, using PAs in emergency rooms or Certified Nurse Anesthetists where anesthesiologists are not available. Only a few interviewees expressed serious concern about the use of physician extenders. One Center said they have opted to only use physicians, as the PAs and NPs cannot help with on-call and/or work in the hospital, while a few physicians expressed concern that extenders were going beyond their scope of practice by presenting themselves as “doctors” and/or were functioning without enough supervision.

Even for those interviewees who supported the use of physician extenders it was pointed out there are limits as to how much support physician extenders can provide. While extenders can assist physicians by seeing additional patients, the increase in patient volume results in more paperwork and more patient calls for the individual physicians who still have the ultimate responsibility for the patients. Additionally, the extenders require supervision by the physician and are not able to relieve the physician burden of being on-call.

Other interviewees also felt there is a disconnect between licensing and billing, e.g., PAs can not bill independently like NPs, a preceptor has to be present so the office can bill more than the 85% of the rate for services provided by a NP or PA.

Telemedicine

Most local hospitals and a few of the Community Health Centers are the prime users of telemedicine with its predominate use being in the area of radiology. Several interviewees also noted they used it for psychiatry and dermatology and/or are considering using it for pathology, rheumatology, orthopedics, ophthalmology, cardiology or medical imaging. In addition to using it for medical services, a number were also using it as a means for making Continuing

Medical Education programs available to rural practitioners. One interviewee was planning to use telemedicine for grand rounds and another suggested practitioners could use it as a “professional chat room”.

There were very mixed reactions to the effectiveness of telemedicine. Only a small group of interviewees enthusiastically supported its use, while the majority either had serious reservations about its benefits or were unfamiliar with how it could be used or what benefits it could offer. Some interviewees felt it would be helpful in remote locations while others felt it would only work in larger rural communities. Several interviewees who were interested in using telemedicine did not have the money needed for the T-1 lines or could not get a T-1 line installed in their area.

Some of the issues that interviewees had with the use of telemedicine included:

- Too much down time, making it more trouble than it was worth.
- Need for a local champion including people who know how to use it appropriately. In a number of cases, individual physicians blocked its use.
- Too expensive and not cost effective, especially for individual physicians.
- Poor images so that appropriate diagnosis related to dermatology or pathology cannot be made.
- Lack of effective reimbursement for the service.
- A general concern about liability issues associated with its use.
- Being a deterrent to visiting physicians continuing their visits to the local communities as their patient load could decrease.
- Abuse of the technology in using it to substitute for direct care. Several interviewees stressed it was important to continue seeing patients face-to-face as patients wanted this more personal interaction with their physicians. This was specifically linked to care provided by primary care physicians or dermatologists who “need to feel the moles”. (Note: One interviewee noted their patients liked telemedicine as it allowed them not to miss work.)

Mobile Diagnostic Equipment and Specialty Clinics

There appeared to be limited use of mobile diagnostic vans and was primarily being used in smaller communities where there either was no hospital or the hospital did not offer the specific diagnostic services provided by the mobile vans. Several of the Community Health Centers said they had access to mobile vans for MRI, ultra-sound, ophthalmology or mammography. Some interviewees thought access to such vans would be helpful since many communities cannot support the full use of such equipment and personnel. However, others did not feel the mobile vans were beneficial because there were not enough people needing the diagnostic services and thus were not cost effective. A more common strategy being employed in the local communities was the use of “visiting physicians” or specialty clinics that are held a number of times a month (see discussion in the previous section on recruitment strategies).

Job and Work Environment

Instead of focusing solely on recruitment, both the local hospitals and many of the Community Health Centers emphasized the need to create a positive and supportive work environment to encourage health professionals to stay in the local communities. In addition to offering competitive salaries, a number of interviewees also tried to structure the practitioners' jobs so they were more appealing. Examples cited included 3-day weekends, flexible hours, time off for Continuing Medical Education classes, enhanced opportunities for collegial-interaction, preceptor program for new RNs, purchasing of the latest equipment, provision of housing. Interviewees also stressed the importance of paying for educational opportunities for their employees, e.g., LPNs to become RNs or training in ultrasound technology. Several hospital administrators felt their turnover rates had dropped dramatically and were now below the State average as a result of these types of efforts.

Implementation of "incentive plans" was another successful strategy that had been implemented by a few Community Health Centers as well as several hospitals. Monetary awards were provided to physicians as well as other health care practitioners who met certain productivity and quality standards. One hospital has established a profit sharing program in which units within the hospital are eligible to receive bonuses, which are paid out twice a year, if the units meet certain standards (e.g. patient satisfaction, worker compensation and productivity targets).

Through a federal Community Access Program grant, Copper Queen Hospital and the Chiricahua Community Health Center have been able to increase provider productivity through electronic infrastructure development in which these entities are able to be connected electronically, have shared practice management systems and transmit all records electronically. This new system allows providers at one facility to have immediate access to the patient's medical records from the other facility; expediting treatment and avoiding duplication of testing.

Finally, one interviewee suggested consideration be given to creating a tax benefit for physicians who practice in the rural areas or to allow medical school debt to be taken as a tax deduction if one practices in a rural area.

Hospitalists and On-Call Arrangements

A number of the physicians felt Flagstaff Medical's hospitalist program was very positive in allowing primary care physicians to use their time more effectively. Another approach taken by a few practices was to have one doctor at a time act as a "hospitalist" for all the practice's patients in the hospital and to also act as the on-call physician for the other doctors in the practice. This strategy prevented all the doctors in the practice from having their schedules disrupted by having to be at the hospital and limited the amount of time spent on-call. The Tuba City Indian Medical Center has been working on establishing on-call agreements with practitioners in Flagstaff so that solo practitioners in their Center will only have to be on-call one (1) out of four (4) nights.

Interns and Residents

The use of interns and residents was not widely cited as a means for extending the productivity of practitioners. Several interviewees (e.g., hospitals) said they were not using interns or residents. For those who were, concern was expressed about the additional amount of physician supervision the interns / residents require.

Barriers to Implementation

In trying to develop appropriate support strategies and/or to extend provider productivity, interviewees noted a number of barriers, which make implementation of these strategies more difficult. These include:

- Accessibility of Training Programs. While a number of interviewees said that they would like to get individuals cross-trained in certain areas, (e.g., use of X-ray, ultra sound) educational programs were not readily available in their region.
- Physical Structure. For several of the interviewees, the physical space of the facility was viewed as a limitation, e.g., not enough exam rooms, limited operating rooms. A lack of available capital made it impossible for them to improve the structures.
- Use of Pharmacy Technicians. Several Community Health Centers were considering using pharmacy technicians to fill prescriptions with supervision via telemedicine by a pharmacist. However, current State regulation would not allow this to occur.

Other Barriers to Accessing Health Care

Although a number of the interview questions, focused around the lack of providers in the local community and the identification of strategies to recruit and retain practitioners, interviewees were also asked to identify other key barriers to accessing health care in their communities and any potential strategies to overcome these barriers. Some interviewees did not identify any major barriers beyond the lack of and access to providers. For those that did, lack of coverage (i.e., insurance) and lack of transportation were cited most frequently. A more detailed discussion of these key barriers and others, as well as strategies employed to overcome these barriers is provided below.

Health Care Coverage

The biggest barrier pointed to by many of the interviewees was the lack of health care coverage (i.e., the uninsured), deterring individuals from accessing health care when appropriate. While a number acknowledged the positive impact implementation of Proposition 204 had on expanding access to coverage in the State, frustration was still expressed in terms of individuals who are ineligible for AHCCCS because they are only a few dollars over the income limit for AHCCCS. An example was given by one physician of a family whose incomes is \$42 over the AHCCCS

income limit and yet to be insured through their employer will cost them \$850 a month so the family is currently “not insured”.

Even if a person is potentially eligible for AHCCCS coverage, a number of issues were identified as preventing them from applying and qualifying for coverage, including:

- Individuals not wanting to apply (e.g., do not want government help, do not want to go through the hassle, do not understand the process, or are afraid of deportation).
- Lack of eligibility worker(s) at the facility or readily accessible in the local community.

Through a partnership between AHCCCS, the Arizona Department of Economic Security (DES) and the Community Health Centers Collaborative Ventures, Inc. (CHCCV), a new Web-based enrollment application called “Health-e-Arizona” has been launched as a pilot at the El Rio Health Center locations in Tucson, and at the DES offices in Pima County and the AHCCCS SSI-MAO and KidsCare Offices. The pilot will be expanded to six (6) other members of the CHCCV throughout the state over the next year. Health-e-Arizona is a paperless interview process using electronic signatures and providing real-time eligibility screening. It offers bilingual English and Spanish versions, which outreach workers can toggle between at any point in the application process. The application is also fully compliant with usability standards and requirements of the Americans with Disabilities Act (ADA). For interviewees from Southern Arizona, the Health-e Application pilot program was viewed as a very positive strategy for making the eligibility process more accessible.

Additionally, several physicians said they try to individually work with the patients to get them on to AHCCCS. Even if they are ineligible, a number of individual physicians both primary care and specialists said they are often willing to work out some type of payment plan with these uninsured individuals for the care provided.

Aside from the recent AHCCCS expansion, other programs such as the Premium Sharing Program and the Pima Community Access Program as well as the role of free clinics or Community Health Centers were cited as positive solutions to addressing the health care needs of the uninsured. However, limitations with these programs were noted such as the current cap and subsequent waiting list for the Premium Sharing Program. Most of the Community Health Centers interviewed pointed to the difficulty uninsured individuals face in getting needed specialty care, as they themselves are only able to offer primary care services to these individuals. While the Centers said they have some specialists who will work with them in terms of providing discounted rates to referred patients, they feel many of these uninsured individuals do not go to see the specialist because they lack the funds. Additionally, the Centers noted that purchasing the needed prescription drugs can be problematical for these patients as often the Centers are only able to provide a very limited supply of needed medications.

While most were concerned about the uninsured, several interviewees also commented on issues associated with individuals who had coverage. This included:

- Health plans which have very limited provider networks so members have a difficult time accessing those in the network and/or have to travel long distances to be able to use a in-network provider.
- Continual changing of health care plans by employers so the employee needs to constantly find new providers who are in the new plan's network. This churning is viewed as having a negative impact on patient care (e.g. prescription drug coordination).
- Limited service coverage by plans, e.g., AHCCCS does not cover adult dental services.

Lack of Transportation

Lack of transportation options was the next most frequently mentioned barrier to accessing health care in the rural areas. However unlike the issue of providers or coverage which was seen as a statewide issue, the lack of available transportation was a particular concern for interviewees practicing in the smaller and/or more remote rural communities such as Ajo, Navajo Reservation, Elfrida, Show Low, Marana, Wilcox, and Dewey. While AHCCCS eligibles were able to arrange for transportation through their health plans, it was felt many other low-income individuals in these communities and the surrounding areas had a difficult time finding private or public transportation to medical appointments. One interviewee noted that many times a patient would be able to find a ride to the initial medical visit but then would not come back for follow-up visits and/or to pick up the prescription. Another interviewee at the Morenci Health Care Center pointed out for a person needing to see a specialist in Tucson and who does not have ready access to a car, the only available option may be to catch the Greyhound Bus at 1 a.m.

Several of the Community Health Centers in the more remote rural communities, have tried to address this issue through the purchase of vans. However, since most are one-vehicle fleets, their pick-up radius is generally limited and/or trips themselves get limited to those in truly desperate situations. In La Paz County, the county has a transportation program with five (5) drivers that will go anywhere in the county.

For the mid-size communities like Yuma, Prescott, and Flagstaff, interviewees did not see lack of access to transportation as being a major barrier. In fact one interviewee felt this issue had been somewhat over stated since everyone in these rural areas has to get to town to buy something (e.g., groceries) and thus can get in for their care at the same time. "People tend to figure out transport." In Casa Grande, the Sun Life Family Health Center found no one took advantage of their offer to pay for cab fares for medical appointments.

Remoteness of Rural Environment

The very nature of the rural environment was noted as an issue in terms of residents being able to readily access health care services. Even for those with cars, it may take patients an entire day to go to a medical appointment, e.g., seeing a specialist in Phoenix. Since this may involve missing a day of work and/or school, interviewees noted these appointments are often delayed until the health care needs become critical. Preventative measures, such as prenatal care visits may be

kept to a minimum number of visits. Compounding these long travel distances are the times when the weather is bad and the roads are impassable, e.g., heavy rainfall or snow.

Access to Health Facilities

The interviewees identified two (2) barriers associated with accessing emergency care. First, were the overcrowded emergency rooms at the hospitals, which often resulted in long wait times. Interviewees felt this situation was being precipitated by the EMTALA requirements, which do not allow patients to be turned away even if they have no ability to pay or their needs are not emergent. For these non-urgent cases, physicians said they were no longer able to arrange for next day appointments with the patient's primary care physician. In addition to EMTALA, interviewees found there was an increase in emergency room usage if the local clinic was closed for the day, if physician appointment wait times were too long and/or if local physician panels were closed. To address this over crowding, hospitals had taken steps such as expanding the number of emergency room physicians and/or establishing fast track urgent care centers in the emergency room, often staffing them with PAs. Additionally, placing more responsibility on the patient, e.g., collecting co-pays for non-emergency use of the emergency room was offered as another strategy for remedying this situation.

The second barrier, numerous interviewees noted was the difficulty they were experiencing in being able to find a hospital bed in the urban areas for patients needing more specialized care. Physicians said they have to spend hours on the phone calling around to different hospitals to see if a bed is available. One physician noted what formerly took four (4) hours could now take between 16 to 20 hours. In addition to delaying needed patient care and absorbing valuable physician time, for clinics like Morenci Health Care Center this creates care delivery issues because under their outpatient license they are only supposed to keep a patient for up to three (3) hours. One physician suggested it would be helpful if there was a clearinghouse they could call to find out where beds were available as opposed to having to call each individual hospital.

Patient Characteristics

For some patients, interviewees felt that the patient's lack of understanding and knowledge about the health care system and their health care needs prevented them from appropriately accessing services from the perspective of both under and over utilizing the system. Several interviewees stressed the need to spend more time educating patients about issues associated with their personal health issues and how to become eligible for public programs. One suggested vehicle for this education was the use of public service announcements on local TV/radio stations or in the local newspapers.

One physician pointed to cultural barriers (e.g., language, cultural beliefs) as impacting the patients' abilities to effectively utilize services. While bilingual staff can help to address this issue, the availability of bilingual staff is often limited.

Border Issues

For interviewees that practiced in communities near the Arizona border there were a number of both international as well as inter-state barriers that were cited including:

- Inability of undocumented individuals to qualify for AHCCCS other than for emergency care.
- Difficulty in being able to coordinate and benefit from services that may be available just on the other side of the Arizona-Mexican border, e.g., there are numerous pediatricians in the “neighboring” Mexican communities but Bisbee / Douglas is not able to draw upon their expertise due to issues such as licensing, credentialing.
- Due to reimbursement issues plans have with out-of-state hospitals, patients may have to travel further to get in-state hospital care instead of traveling the shorter distance to an out-of state hospital (e.g., Fredonia residents having to travel to Kane County Hospital in Kanab [10 miles] as opposed to Page Hospital in Page [104 miles]).
- Difficulty in getting payment from non-Arizona Medicaid programs (e.g., Medi-Cal for patients obtaining care here in Arizona).

Effective Health Care Coverage Strategies and Provider Participation

In responding to this question, the interviewees primarily answered from the perspectives of identifying health care coverage strategies, which providers found most “effective” and in which they were willing to participate. There was great variation across the State in terms of their responses ranging from those that were willing to accept any coverage plan to those who were very selective. One physician said while he finds it difficult to work with some of the coverage options, he will contract with them in order to accommodate his patients who often have no choice as to which plan they have to use. There was also no consistency in terms of which coverage plans they disliked, e.g., AHCCCS, Medicare, health maintenance organizations (HMOs), TriCare. For most, the reimbursement rates and the “hassle” factor were the key drivers in determining whether they would contract with a plan. One interviewee commented that he “doesn’t sign a contract is worse than what the other contracts he currently has in place for himself” while another physician noted that one has to limit how many poor payors one will contract with making sure that one has some high payors.

Other responses to this question included:

- The Community Health Centers in keeping with their mission accepted all types of coverage plans, including the provision of primary care services to the uninsured on a sliding fee scale. In addition the Centers strongly advocated for the continued use of Tobacco Tax monies to support primary care services, including the provision of prescription drugs. They viewed this funding as being very important and effective in terms of providing needed care to the uninsured.
- A number of interviewees made the observation that new physicians tend to be willing to accept AHCCCS patients but as their practices grow they generally become more

selective; putting limits on the number of AHCCCS patients they will see. This imposed limitation is a response to the perception AHCCCS members are very demanding and time consuming but reimbursement for services provided to them is low. Additionally, some physicians noted due to problems encountered with some of the AHCCCS plans they have opted to limit with which plans they will contract.

- For some, preferred provider organizations (PPOs) were cited as the type of coverage which both the patients and providers liked the best, as these plans involved less paperwork, were more accessible to the patient and had simpler authorization processes in place.
- Except for AHCCCS, HMOs were not a coverage option in many parts of the State, e.g., Yuma, Prescott. One physician noted that they “don’t have mangled care” in their town.
- In several communities, interviewees said physicians were dropping or limiting the number of Medicare patients they would accept due to the low reimbursement rates. Many were continuing to see current patients but would not accept any new Medicare patients or people over 50 years of age. However, other interviewees liked Medicare specifically citing their prompt payments and ease in billing.
- None of the interviewees expressed interest in discount cards. One interviewee noted no one in Prescott will accept discounted fees making this strategy unrealistic and another felt sliding fee schedules are better in that they adapt to the needs of the client.
- A number of the local regional hospitals said they are selective about the type of contracts into which they will enter; limiting the size of the discounted rate they will accept.

Needed Legislative Action

The interviewees offered a wide range of suggestions with regard to issues and/or action steps they would like to see the Arizona State Legislature address. Three (3) consistent themes that emerged were the need 1) to control the increasing malpractice rates through tort reform, 2) to provide incentives for physicians to practice in rural environments and 3) to continue allocating Tobacco Tax monies for primary care services. A more in-depth discussion of these three issues is provided below.

Malpractice Rates. The physicians and hospitals felt the Legislature needed to address the increasing rates for malpractice insurance. (Note: This is not an issue for the Community Health Centers as their practitioners are covered under the federal tort law.) Interviewees felt the increasing rates for malpractice insurance made it more difficult for physicians to continue making a living in these rural communities. Although physicians covered under Mutual Insurance Company of Arizona (MICA) noted that their rates only increased around 4% to 5% this year other individuals not insured by MICA were experiencing rate increases of 20% to 35%. There was particular concern about the impact this was having in the area of obstetrics. Examples were given of several family practitioners who were ceasing to provide obstetrical services and a local obstetrician who quit recently and moved back to New Mexico when he was quoted a rate of \$150,000. One surgeon whose premium is \$44,000 questioned even the value of having

this coverage since it only covers up to \$1 million yet the average award is \$3 million. Suggestions made to address this issue included tort reform and the limiting of damages, recognizing this would require a change in Arizona's Constitution. Other interviewees suggested subsidizing the premium rates for rural practitioners, especially obstetricians.

Incentives. A number of interviewees felt it was important to provide "financial" incentives to practitioners who were willing to practice in the rural communities, including the Indian Reservations. This was viewed as a key strategy in both recruiting new physicians into these rural areas as well as encouraging current practitioners to stay. For recruitment purposes numerous interviewees advocated for the enhancement of the loan repayments programs both in terms of increasing the size and number of available loans as well as broadening of the type of practitioners who could qualify for the loans (e.g., RNs, dentists, behavioral health practitioners). Continuation of the J-1 visa waiver program was also supported. Many interviewees felt, however, it was important to re-look at the criteria for designating the shortage areas which qualify for these programs; allowing additional communities to qualify such as Yuma, Pinetop, Flagstaff, Safford, Globe, Sierra Vista. Other possible incentives cited included:

- Assistance with malpractice rates especially if the practitioner is willing to care for AHCCCS members.
- Increase in the reimbursement rates for rural practitioners.
- Tax credits for rural practitioners, e.g., for providing charity care or care in general in underserved areas or for payment of malpractice premiums.

Tobacco Tax Monies. All the interviewees representing the Community Health Centers identified the need for the State Legislature to continue allocating Tobacco Tax dollars for primary care services, including prescription drugs to low-income populations. However, in continuing this funding interviewees suggested the current State reporting requirements as it relates to the delivery of primary care services be re-evaluated and streamlined. Finally, a number advocated for additional Tobacco Tax monies to be set aside for construction grants (i.e., capital improvement projects) to Community Health Centers.

Unlike the three issues discussed above there was less consistency among the interviewees as to other recommended action steps they would like to see the Legislature take. These additional suggestions, however, can be grouped into several broad topic areas, e.g., system reform, insurance mandates and reform, transportation; a summary of which is provided below.

System Reform. A number of interviewees cited the need for major health care system reform. The current system for financing health care was viewed by one physician as a band aid approach with reform needing to come from the states. Other system reform suggestions included adopting universal health care, instituting no fault insurance for health care, looking at the Oregon approach of rationing health care, reforming the behavioral health system in Arizona by eliminating the role of the Regional Behavioral Health Agencies, analyzing and then implementing a demonstration for a rural health

care delivery system (e.g., creation of urgent stabilization centers with transport to regional health centers).

Federal Laws and Regulations. While interviewees recognized the State Legislature did not have the authority to make improvements to the federal EMTALA laws and regulations they felt the State should at least advocate and support changes at the national level. In addition to EMTALA suggestions were made for the federal government to decrease the number of unfunded federal mandates and to reconsider the requirements under Health Insurance and Portability Act (HIPAA). The federal EMTALA and HIPAA requirements were thought to be very onerous and to interfere with the practitioner's ability to take care of his/her patient. Additionally, other interviewees pointed to federal "body part" legislation such as 48 hour maternity stays or lead screening of all Medicaid eligible children, which limit the ability for physicians to practice in a more sensible and cost effective way.

Reimbursement Rates. In addition to serving as a means to incentivize physicians to practice in rural areas, many felt there was an overall need to increase reimbursement rates to adequately compensate providers for the costs of delivering care in rural areas of the State. One group of physicians noted that it was important for government to understand the consequences of reducing Medicare/Medicaid rates, as there may be no "savings" to the system if for example a 5% drop in the rates results in physician shortages.

Insurance Mandates and Reform. A number of interviewees focused on the need for insurance reform to make rates more affordable by preventing cherry picking and allowing better pooling of the risk. One practitioner suggested requiring all insurers to treat the entire State as a risk pool thereby selling insurance to small rural employers at the same rate it is sold to large urban employers. Another interviewee suggested the creation of larger purchasing pools by allowing employers to form coalitions to purchase health care. Additionally, another person suggested premium rates should take into account an employer's health history, giving credit for those healthy years.

Interviewees also identified changes, which could be made to insurers' current operations to allow increased provider efficiency. This included ensuring claims are paid on time (i.e., enforcement of the clean claim rule), adopting Colorado legislation in which all claims are paid up front pending medical review, requiring all insurance companies to use the same forms (e.g., prior authorization forms), reducing the amount of paperwork associated with billing and revamping and streamlining the credentialing process.

Other suggestions related to insurance mandates and reform included:

- Establish standards, which would ensure that at least a basic minimum is covered by the policies.
- Mandate elimination of managed care as it is driving physicians away.
- Modify the current statute, which requires all provider contracts to include language requiring physicians to continue to take care of assigned patients until

the contract ends even if the plan goes belly-up and is no longer reimbursing the physician for the care be provided.

Transportation. The need to improve both the non-emergency and emergency transportation systems in the rural area was cited by a number of interviewees. In addition to basic enhancements to the current system (e.g., timeliness, reliability and affordability), one interviewee suggested the rural areas would benefit by training the emergency medical service (EMS) staff to provide a higher level of services than they are allowed to provide under current regulations.

Health Education. A number of interviewees felt the Legislature should affect the way public funds allocated to the State health professional schools (e.g., University of Arizona Medical School, community college nursing programs) are being spent to ensure these publicly-funded programs are designed to address health care staffing needs in the State. In particular interviewees suggested the schools' entrance requirements be re-examined such that greater consideration be given to students who either come from local rural communities in Arizona or are committed to practicing in the rural areas after graduation (see discussion in recruitment strategy section of the report). One example was given of several rural hospital employees who wanted to get into the local nursing program at the community college and who were denied as no preference was given to applicants from the local community. At a minimum it was suggested that all resident and medical students be required to do a rural rotation so they would at least better understand the rural health care environment. Finally, it was suggested the Legislature look at expanding both the number of slots and the types of programs offered at the local colleges in order to help address some of the current health care staffing shortages in the State (e.g., nursing, technicians).

Professional Licensing Boards. Physicians identified a number of professional health care licensing Board requirements for which consideration should be given to changing. These included:

- Streamlining the process for getting a physician licensed in the State.
- Amending the statutes so specialty physicians do not have to take the specialty exams again if they have been out of school for more than a 10-year period.
- Changing the statute for PAs so that they could practice and bill independently like NPs.
- Re-evaluating the new medical assistant certifications requirements in terms of restrictiveness.
- Amending the requirements to allow pharmacist technicians to dispense medication by utilizing telemedicine supervision by pharmacist.

Other Recommendations. Aside from all the recommendations above, other suggestions made by individual interviewees included but were not limited to:

- Requiring specialty hospitals to assume some of the costs associated with providing care to uninsured low-income individuals, e.g., ERs.

- Providing funding for items such as health services provided to undocumented individuals, cost of practitioners to fly to small rural communities, Premium Sharing Program so there is no cap, graduate medical education and specialty care provided to low-income, uninsured individuals.
- Addressing the issue of the uninsured by expanding AHCCCS eligibility, by providing insurance coverage for low-income individuals and/or those uninsured between 55 to 65 years of age who are too young to qualify for Medicare, or by providing incentives for small employers and individuals to purchase coverage.
- Making changes to the AHCCCS programs such as requiring the members to be more responsible for their care (i.e., co-pays), not allowing individuals to qualify for AHCCCS if they have other coverage.
- Supporting the trauma centers, making use of the plan recently developed by the State-appointed task force on trauma centers.
- Educating the public about the value of physicians.
- Establishing mechanisms (e.g., regional planning councils) to better control where physicians set up practices so that a community's health care needs are more effectively met.

Issues Health Plans Need to Address

In responding to the question of what key issues practitioners felt health plans needed to address in order to improve providers' ability to deliver health care to their patients, interviewees consistently identified a number of key areas applicable to both the commercial as well as the AHCCCS health plans. An overview of these concerns is provided below. While not the prime focus of the study, interviewees were also asked about any specific concerns that they had with regard to the AHCCCS plans, the intent being to have AHCCCSA staff address those concerns separate and apart from this study.

Paperwork

The need to reduce the paperwork demands on practitioners and simplify the system was universally mentioned as a major issue needing to be addressed by the plans. Physicians were feeling overburdened by the paperwork requirements and resented that it was taking time away from being with their patients and/or requiring lots of after hour work. It was also seen as contributing to higher costs for providing care. One physician estimated that 1/3 of her time was spent on paperwork and when she stopped contracting with the AHCCCS health plans she was able to eliminate two (2) support staff in her office. One surgeon said he sometimes just simply refuses to do the required paperwork. Specific paperwork-related issues cited by the interviewees included need to bill multiple times, excessive documentation requirements associated with billing, prior authorization requirements (see below) and cumbersome referral processes.

Prior Authorization

Two (2) different issues were identified with regard to the health plans' prior authorization processes. The first issue relates back to physicians' concerns about the amount of paperwork and time required to obtain prior authorizations. A number of interviewees wanted to see the plans improve the speed and reliability of the process, complaining about the amount of time their office staff, including nursing staff with formulary issues, was kept on hold. Additionally, suggestions were made to mandate the use by health plans of a universal prior authorization form and reduce the prior authorizations required for non-formulary drugs. The second issue regarding prior authorization was an overall concern about prior authorization. Several interviewees did not like to be told what tests are or are not necessary for his/her patients or wanted to see the complete elimination of the gatekeeper concept.

Credentialing

All the Community Health Centers felt the credentialing process needed to be streamlined. It was viewed as both duplicative and too lengthy a process (i.e., 6 to 12 months to complete). The long delays created financial problems for the practitioners who, pending completion of the credentialing process, are not able to either see patients from those plans or if they do will not get reimbursed for patients they see. It also delayed the ability for the new physician to relieve the workload of the physicians currently practicing in the community. One Center gave the example of a physician who has been practicing in Sierra Vista and is now coming to practice in Bisbee but since she is changing locations two of the health plans with which she was already contracted with in Sierra Vista says she has to be credentialed again.

Reimbursement and Claims Payment

As discussed in the previous section on needed legislative action, reimbursement rates and payment of claims again emerged as a concern among some of the interviewees. Several interviewees felt it was important to pay more for primary care services and to establish different rates for practitioners in the rural vs. the urban environment. While many interviewees felt rates needed to be increased others felt the rates paid by most plans were reasonable or too high in some cases. In terms of claims payment, a number of physicians and hospitals had issues with the plans not paying in a timely manner (e.g., claims outstanding for 70 to 90 days). Several interviewees said they would be more willing to live with the "low" rates if some of the paperwork requirements were reduced and/or if claims were paid promptly.

General Operations

Issues revolving around the overall health plan operations were also raised by the interviewees, including:

- Need for plan medical directors to be local or at least be more sensitive to the local community so they could better understand and address the care issues in the community.
- Improvements in the area of the customer service, e.g., prompt return of phone calls, more frequent visits by provider representatives, an actual person answering the phone.
- More assistance with referrals to specialty doctors, especially if the plan has no contracted specialist in the area.
- Improvements in case management / patient management, especially with non-compliant patients.
- Need for more consistency between the health plan formularies while at the same time ensuring appropriate drugs are included on the formularies and updated formularies are provided to practitioners in a timely manner.
- Expediting the process for physicians to sign up with plans, so new physicians are able to start seeing plan members sooner.
- Flexibility in the use of the health plans sole source laboratory service contracts, especially in the more remote locations where it would be more expeditious to perform some of the tests on-site.

Other Issues

Other suggestions included the need for health plans to:

- Require meaningful co-pays for non-emergency use of the ER.
- Do a better job of explaining coverage and limitations under the member's plan policy.
- Consistently applying the plan rules, e.g., example given of where the progress notes were accepted with the physician bill but rejected with the hospital claim.
- Help local communities with the recruitment of physicians.

Characteristics of Rural Provider Practices

The set of questions related to individual health care practitioner's own practice were primarily responded to by physicians and the Community Health Centers. Even then the responses were more limited as in many of the physician group meetings, time did not permit the gathering of individual physicians' responses to these questions. In addition to these practice related questions, descriptive information was gathered about each interviewees practice or facility and his/her service area. While this more descriptive information about the specific aspects of each individual practitioner's practice is not included as part of this report, a summary is provided below of some of the more common characteristics that emerged with regard to rural provider practices.

Patient Mix

From the responses received, there are some general trends in patient mix. The health centers interviewed appear to be providing services to more uninsured and AHCCCS members than hospitals or physicians. Some physicians choose not to provide services to the Uninsured, AHCCCS members, and Medicare patients. The majority of hospitals and physicians interviewed also appear to be treating a higher number of Medicare and commercial patients than health centers. See the following chart for response averages and ranges.

AVERAGE				
	Uninsured	AHCCCS	Medicare	Commercial
Health Center	34%	32%	11%	26%
Hospital	12%	18%	45%	23%
Physicians	9%	15%	42%	33%

RANGE				
	Uninsured	AHCCCS	Medicare	Commercial
Health Center	3% - 55%	22% - 40%	5% - 30%	11% - 40%
Hospital	6% - 23%	8% - 34%	28% - 64%	6% - 40%
Physicians	0 - 23%	0 - 40%	0 - 70%	5% - 70%

Referral Patterns

Most providers preferred to refer patients locally or to a nearby location, if possible. However, the majority of referrals were to the three more urban areas of Arizona: Phoenix, Tucson, and Flagstaff. Some interviewees along the Arizona border have referral patterns to San Diego, California; Las Vegas, Nevada; Albuquerque, New Mexico, and Gallup New Mexico.

Impact of Coverage Source

In concert with their mission, the Community Health Centers accepted all coverage types. For these Centers the coverage source primarily impacted them in terms of referring uninsured individuals for specialty care as these patients often had no money to pay for the care. This broad acceptance of any coverage source was not true with the physicians. While some of the physicians accepted all coverage types, others limited or did not accept AHCCCS and/or Medicare patients, and others would not contract with specific health plans. The older and more established physicians tended to be more selective in the type of patients they would take. A number of the physicians commented that the AHCCCS patients tended to be more demanding; requiring more of the physician's time. While treatment of the patient was the same regardless of coverage type, physicians as well as the hospitals felt there was a difference in the adequacy of the reimbursement by coverage types which in turn financially impacted their practices /

facilities. However, there was no consistency among the interviewees in terms of which coverage types were viewed as good or bad payors.

Capacity of Practices

Most of the physicians interviewed felt their practice was at or near capacity with a few looking to bring an additional practitioner into their practice. For the physicians the responses in terms of future patient loads varied as a number of them were nearing retirement and/or were looking to scale back their practices, while a few said they were looking to expand by bringing another physician to the practice. For the hospitals, a number of them were experiencing an increased demand for emergency room services resulting in overcrowding and long waits. Sierra Vista Regional Health Center said they had seen a 20% increase in volume this year, despite the fact that overall growth in the community is flat.

The current capacity at the Community Health Centers varied. Only a few Centers (Morenci Health Care Center, Desert Sentita Community Health Center) said that they had the capacity to take more patients. The other Centers all had at least one site (main clinic or satellites) that was at or near capacity. Often these same Centers were in the process of expanding the size of the facility and/or hiring additional practitioners to address the capacity issues. Additionally, the Centers all said they would continue to see more patients in the next few years and this past year had developed with the assistance of the Arizona Association of Community Health Centers a Five-Year Growth and Resource Plan. As reflected in this plan (and confirmed by the interviews) all of the Centers are planning over the next five years to expand their access sites and/or add additional services such as dental, behavioral health and pharmacy.

Many of the local regional hospitals that were interviewed (e.g., Mt Graham Community Hospital, Cobre Valley Community Hospital, Kingman Regional Medical Center, Western Arizona Regional Medical Center, Havasu Regional Medical Center, Yuma Regional Medical Center) had or were in the process of both renovating and/or expanding their facilities in order to be able to effectively serve more patients in future years.

NEXT STEPS

As a result of the information obtained through these interviews, AHCCCSA has identified the following four (4) next steps:

- Communicate relevant information to stakeholders. AHCCCSA plans to provide each of the interviewees with a copy of the project report. In addition, AHCCCSA will, if appropriate, meet with other key stakeholder groups to provide an overview of the project findings as well as to discuss specific issues that were raised which involve them in some capacity. Examples of stakeholder groups include Arizona Association of Community Health Centers, Arizona Medical Association, Arizona Osteopathic Medical Association, Arizona Department of Health Services and University of Arizona, College of Medicine. Finally, the project findings will be shared with other interested parties such as the U.S. Department of Health and Human Services, Health Resources and Services Administration and Center for Medicare and Medicaid, St. Luke's Charitable Health Trust and the Rural Health Office at the University of Arizona who is currently working on developing a comprehensive rural health plan. The project report will also be posted to the Web site <http://www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA>.
- Provide project findings and specific recommendations to Legislature. AHCCCSA will present the relevant project findings to both the Statewide Health Care System Task Force as well as the Rural Physician Study Committee. The comments related to malpractice rates and the need for tort reform will be of particular concern to the Rural Physician Study Committee as this is a key area of focus, while the input regarding strategies to improve rural infrastructure will be of interest to the Statewide Health Care System Task Force.
- Follow-up on specific AHCCCS related issues. Interviewees identified a number of AHCCCS related issues as it related to eligibility, reimbursement, provider network and other health plan operational concerns. AHCCCSA has compiled a detailed listing of these issues and is currently working on researching and resolving the issues. In addition, several of the issues raised such as hospital reimbursement and the Community Health Centers' concern about the current credentialing process are already being addressed through formalized work groups.
- Conduct further research on specific issues. Through these interviewees a number of other issues were identified which would require additional research and analysis by other responsible entities (e.g. Department of Health Services, Board of Medical Examiners). AHCCCSA will discuss these issues with the appropriate entities. Examples of areas that have been identified as possibly requiring further analysis include:
 - Statutory issues related to practitioner licensing requirements.
 - Program requirements for the J-1 visa waiver program and the criteria for underserved areas.
 - Identification of potential improvements to current loan repayment programs.

- Exploration of strategies for professional schools in Arizona to employ to enhance their students' willingness to practice in rural communities and their understanding of rural health care issues.
- Other states' requirements regarding claims payment, e.g., Colorado legislation allowing claims to be paid first prior to any reviews.

CONCLUSIONS

As a result of this study the AHCCCSA HRSA project team has gained invaluable information about barriers to the development of a stronger rural provider infrastructure in the State and potential strategies to overcome these barriers. By traveling around the State to the individual rural communities the policy makers were able to experience “first hand” the challenges faced by practitioners delivering health care in these remote areas. It became evident that any proposed solutions must carefully consider both the general features of the rural environment as well as be tailored to the unique needs of each rural community. For example, while telemedicine appears on paper to offer great potential for increasing access to health services in remote areas, there are clearly a number of barriers that have to be overcome before it becomes a successful strategy, e.g., installation of T-1 lines, and in some cases local provider resistance.

In addition to the valuable information obtained from the interviews, the project also provided many rural practitioners the opportunity to tell their story and assist with efforts to make improvements in the current delivery system. Numerous interviewees expressed appreciation over the fact individuals in government had made the effort to come out to their rural communities to learn about their issues and concerns.

Finally, the findings from this project have reinforced the importance of the Statewide Health Care System Task Force’s charge to look at strategies for improving the rural health care infrastructure in concert with the development of an accessible and affordable health care system statewide. From this study, and additional research and analysis, it is hoped the State will be able to implement effective strategies to address the needs of the rural communities by building stronger health care infrastructures and improving the accessibility and affordability of health care for the rural residents.

APPENDICES

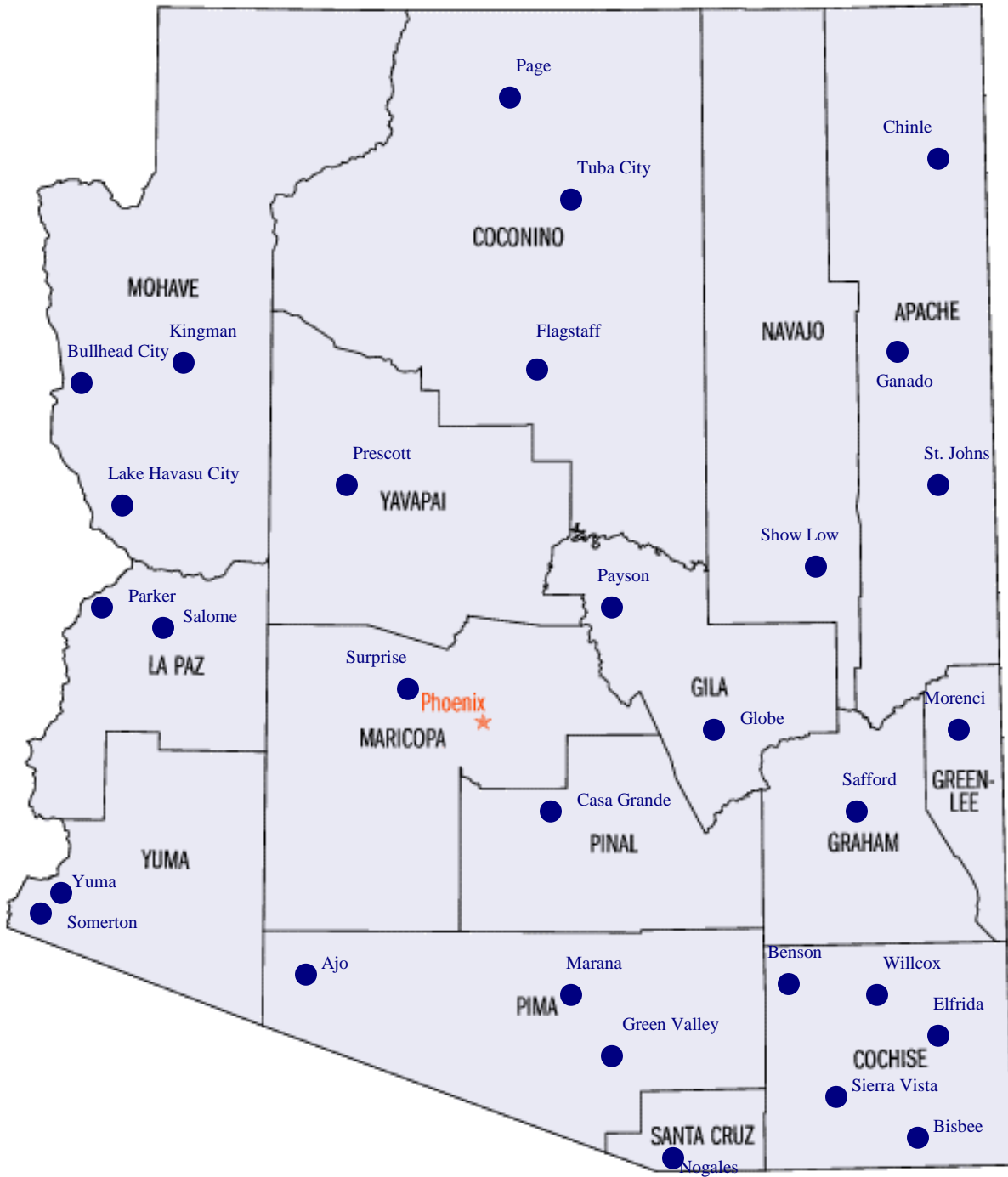
Appendix A: List of Interviewees

Interviewee	City/Town	County
1. Sun Life Family Health Center: Al Gugenberger, CEO	Casa Grande	Pinal
2. Douglas E. Parkin, MD: Internal Medicine/Pediatrician	Casa Grande	Pinal
3. Desert Sentita Community Health Center: Bertha Hickman, Executive Director	Ajo	Pima
4. Copper Queen Hospital: Jim Dixon, CEO	Bisbee	Cochise
5. Chiricahua Community Health Centers, Inc.: Ginger Ryan, CEO	Elfrida	Cochise
6. Progressive Healthcare Group, Inc., Michael Gray, MD, Medical Director	Benson	Cochise
7. Cobre Valley Community Hospital: Charles Bill, CEO	Globe	Gila
8. Capstone IPA: Brian O'Sullivan, Executive Director	Globe	Gila
William Bishop, MD: Internal Medicine		
Michael Durham, MD, Treasurer: General Practice		
Amalia Pineres, MD: Family Practice		
Holly Rooney, MD: Family Practice		
McClaren Ruesch, MD: Family Practice		
Hector Salazar, MD, President: Family Practice/OB		
Linda Serna, MD: General Surgery		
Gary Gustason, MD: Ophthalmology		
9. United Community Health Center: Laurie Jurs, MPH	Green Valley	Pima
10. Marana Health Center, Inc.: Clarence Vatne, Executive Director	Marana	Pima
11. Morenci Health Care Center: Cynthia Sanders, Executive Director; James Zent, MD, Medical Director; Sharon Farrington, Administrative Assistant; and Billing Clerk	Morenci	Greenlee
12. Mariposa Community Health Center: James Welden, CEO	Nogales	Santa Cruz
13. Mount Graham Community Hospital: Pat O'Brien, CFO; Jeanne Carpenter, RN; and physicians below:	Safford	Graham
Susan Jones, MD: Family Practice		
Joel Wright, MD: Family Practice		
Brian Kartchner, MD: Family Practice		
Rex Bryce, MD: Orthopedic		
14. Sierra Vista Regional Health Center: David Ressler, President/CEO	Sierra Vista	Cochise
15. Sierra Vista Physician Meeting	Sierra Vista	Cochise
Richard Weyer, MD: Dermatologist		
Alan Osumi, MD: Radiologist		
Guery Flores, MD: Pathologist		
16. Northern Cochise Community Hospital: Chris Cronberg, CEO	Willcox	Cochise
17. Kevin Rand, MD: General Practice	Chinle	Apache
18. Navajo Health Foundation: Melvin Pataschnick, CEO	Ganado	Apache
19. North Country Community Health Center: Ann Roggenbuck, MPH, MBA, Ph.D., Executive Director and Susan Collins, RN, C/FNP, HCG, Clinic Operations Director	Flagstaff	Coconino
20. Bradford Croft, DO: Family Practice	Flagstaff	Coconino
21. Flagstaff Medical Center and Northern AZ Healthcare: Joseph Kortum, President/CEO	Flagstaff	Coconino

Interviewee	City/Town	County
22. Flagstaff Physician Meeting: Steve Carlson, FMC President	Flagstaff	Coconino
William J. Austin, MD: Pediatrician		
L. George Hershey, DO: Family Practice		
Charles W. Swetnam, MD: Family Practice		
Harold Figueroa, MD: Psychiatrist		
Thomas Gaughan, MD: Psychologist		
Steven Hoover, MD: Neurologist		
Thomas W. Johnson, MD: Neurologist		
Douglas Lee, MD: Anesthesiologist		
Phillip Williams, MD: Obstetrician		
Donald D. Hales, MD: Orthopedist		
Timothy Bonatus, DO: Orthopedist		
Nathan Avery, MD: Neurosurgeon		
Theodore Lewis, MD: Pulmonologist		
23. Walter Taylor, MD: Family Practice	Flagstaff	Coconino
24. Canyonland Community Health Center: Sara Allen, Executive Director	Page	Coconino
25. Dudley Beck, MD: General Practice	Tuba City	Coconino
26. Mark Ivey, MD: Family Practice and Sandy, Administrator	Payson	Gila
27. Bob Ciccarelli, Physician Assistant	Spring Valley	Yavapai
28. Harry L. Gale, DO: Internal Medicine/Geriatrics	Prescott	Yavapai
29. Community Health Center of West Yavapai: Peggy Nies, Director	Prescott	Yavapai
30. Yavapai Regional Medical Center: Tim Barnett, CEO; Doug Bristo, CFA; and Kevin Keighron, COO	Prescott	Yavapai
31. Prescott Physician Meeting	Prescott	Yavapai
Robert Matthies, MD: Family Practice		
William Thrift, MD: Family Practice/Emergency Medicine		
32. Navapache Regional Medical Center: Leigh Cox, CEO and management team	Show Low	Navajo
33. Show Low Physician Meeting	Show Low	Navajo
William Waldo, MD: General Surgeon		
Veronica Dowling, MD: Orthopedics/ArMA President		
S. Steven Mehta, MD: Internal Medicine/Cardiologist		
Leland Reeck, MD: Family Practice		
34. Christine Jackson, MD: Internal Medicine/Emergency Medicine/Cardiologist	Show Low	Navajo
35. St. John's Family Health Center: Terry Leaf, Head of White Mountain Health District	St. John's	Apache
36. Western Arizona Regional Medical Center: Ruth Padilla, Director of Marketing	Bullhead City	Mohave
37. Cynthia Brennan: MD, Family Practice	Bullhead City	Mohave
38. Hesham Sahaweh, DO: General Surgery (written response)	Kingman	Mohave
39. Dale Parry, DO: General Practice (written response)	Kingman	Mohave
40. Kenneth D. Jackson, MD: Family Practice/Obstetrics	Kingman	Mohave
41. Mahmood Khan, MD: Internal Medicine, met with office staff only	Kingman	Mohave
42. Kingman Regional Medical Center: Brian Turney, CEO	Kingman	Mohave
43. Havasu Regional Medical Center: Chad Patrick, CEO and Patrick Kowalski, CFO	Lake Havasu	Mohave

Interviewee	City/Town	County
44. Lake Havasu Physician Meeting	Lake Havasu	Mohave
Lorraine Byrd, DO: Pediatrician		
Kelly Ward, DO: Family Practice		
Michael Ward, DO: Emergency Medicine		
William Binder, MD: Orthopedist		
Scott Graham, MD: Orthopedist		
Walter K. Sosey, MD: Internal Medicine		
Craig Diehl, MD: Pediatrician		
Erin Collins, Member of the Legislative Task Force		
45. Jeff Baird, DO: Family Practice/Osteopathic Manipulative Medicine	Parker	La Paz
46. La Paz Regional Hospital: Vicky Clark, CEO	Parker	La Paz
47. McMullen Valley Chamber of Commerce: Cheryl Montijo, Director and 2 members from TriValley Medical Association for the local Salome clinic	Salome	La Paz
48. Sunset Community Health Center: Whitney, Reel, Clinic Manager	Somerton	Yuma
49. Clinica Adelante: Linda Gorey, CEO	Surprise	Maricopa
50. Dale Webb, MD: General Surgeon	Yuma	Yuma
51. Yuma Regional Medical Center: Bob Olsen, Administrator and Todd Hirte, Contract Administrator	Yuma	Yuma
52. Yuma Physician Meeting	Yuma	Yuma
Bertram Carson, DO: Family Practice/Emergency Medicine		
Robert Cannell, MD: Pediatrician (Member of the Legislative Task Force)		
Hank Carter, MD: General and Vascular Surgeon		
Lee Hieb, MD: Orthopedist/Chief of Staff		
Ismael Guerrero, MD: Family Practice		
Robert Garcia, MD: Family Practice		
Timothy Graham, MD: Anesthesiologist		
John Carson, MD: Emergency Medicine/Psychiatrist		
Andrew Meyer, MD: Internal Medicine/Cardiovascular Disease		
53. Thomas McWilliams, DO: Past President of the Arizona Rural Health Association and Associate Dean of the AZ College of Osteopathic Medicine		N/A

Appendix B: Map of Interviewees Location



Appendix C: Sample Letter to Potential Interviewee

(Note: This sample letter is to request a face-to-face meeting with an individual physician, other versions of this letter were sent out for interviews which would be done as telephone interviews or as group meetings.

Dear _____:

Last year the AHCCCS Administration was the recipient of a federally-funded state planning grant to facilitate the development of a plan for providing Arizonans with affordable, accessible health insurance. As a result, the AHCCCS Administration in conjunction with Arizona's Statewide Health Care Insurance Plan Task Force, has been examining the issues involved in making health care accessible and affordable to all Arizonans.

One of the key issues that has been identified is the need to strengthen and improve the rural health care infrastructure, including implementation of effective strategies for enhancing the rural provider network. In order to better understand the issues faced by rural practitioners, the AHCCCS Administration will be conducting key stakeholder interviews with rural health care practitioners in April and May. Through these interviews we also hope to solicit suggestions as to potential solutions for supporting and enhancing the rural provider network.

Physician input is critical to this process. You were identified by (*insert referral source*) as one of the key practitioners in (*insert city*) with whom we should talk. In order to solicit your input regarding issues faced by rural practitioners, AHCCCS representatives would like to set up a meeting with you in your office which should last approximately 1 hour. If feasible we would also like to arrange to talk separately with your administrative office staff for additional operational details related to providing care in the rural areas of the State.

A member of our staff will be contacting your office in the next week in order to identify possible dates for a meeting. Prior to the meeting we will send you out a list of questions for which we are seeking your input. We recognize that your time is limited and appreciate your willingness to assist us. We are looking forward to meeting and talking with you. If you have any questions please do not hesitate to give me or Anna Shane at call at (602) 417-4241.

Sincerely,

C. J. Hindman, M.D.
Chief Medical Officer, AHCCCS

Appendix D: Rural Provider Interview Questionnaire

AHCCCS Rural Health Care Provider Meetings General Interview Questions

1. Access to health care has been identified as a significant problem for rural residents. Lack of rural health care practitioners has been cited as a key contributing factor. The impact of this factor differs in each rural area. Based on your community, please respond to the following:
 - Do you feel that a lack of rural health care practitioners in your area of the state is a problem and contributes to rural residents' inability to access health care services? What (if any) types of practitioners are lacking, e.g., generalists, specific specialty providers?
 - Why is it difficult to recruit practitioners and/or why do practitioners leave your area?
 - What strategies have or should be implemented to support existing practitioners; encouraging them to continue to practice in your area?
 - What strategies have been effective in recruiting practitioners to practice in your area of the state, e.g., loan repayment programs, scholarship programs, clinical education rotation programs, J-1 visa waiver, career education programs? What additional strategies could be implemented?
 - Other than a lack of practitioners, what other factors would you identify (in order of importance) as key barriers to accessing health care in your area of the state?
 - What strategies have been effective in addressing these other barriers and/or should be implemented?
2. What type of strategies do you feel would be effective in extending the productivity of the limited number of practitioners in the rural areas, e.g., use of physician extenders, telemedicine, transport to urban tertiary centers, mobile diagnostic equipment, cross-training of practitioners? Which of these strategies do you currently employ?
3. What type of health care coverage strategies (e.g., PPO, HMOs, discount cards) and/or programs (e.g., HealthCare Group, safety net programs, employer sponsored) do you feel afford individuals accessible and affordable coverage and which types of coverage programs are you willing to participate in as a provider?

4. What two (2) things do you feel the State Legislature could do to improve the health care infrastructure in the rural areas of the State?
5. What two (2) things do you feel the health plans with whom you are now contracted (either AHCCCS or commercial plans) could do to improve your ability to provide health care to your community?

Note: The following question is for individual health care practitioners.

6. In order to better understand the issues being faced by rural health care practitioners, the following questions relate to your practice:
 - What percent of patients seen in your practice are:
 - a. Uninsured_____
 - b. Covered by AHCCCS_____
 - c. Covered by Medicare_____
 - d. Covered by commercial insurer_____
 - Does the patient's coverage source impact your practice? If yes, how?
 - How close to maximum capacity is your practice currently? Do you have any plans for expansion?
 - Do you anticipate seeing more or fewer patients in the next two years? Are there specific coverage groups to whom you will no longer provide care? If yes, why?
 - How has your practice changed in the last five years?
 - To what community do you typically refer patients for specialty or hospital services?

Note: The following question is for large clinics or large group practices.

6. In order to better understand the issues being faced by rural health care practitioners, the following questions relate to your clinic(s):
 - How many clinic sites do you currently operate and where are they located?
 - What percent of patients seen in your clinic(s) are:
 - e. Uninsured_____
 - f. covered by AHCCCS_____
 - g. covered by Medicare_____
 - h. covered by commercial insurer_____

- Does the patient's coverage source impact the operation of the clinic? If yes, how?
- How close to maximum capacity is clinic? Do you have any plans for expansion?
- Do you anticipate seeing more or fewer patients at the clinic(s) in the next two years?
Are there specific coverage groups to whom you will no longer provide care? If yes, why?
- How has the clinic's operation changed in the last five years?
- To what community do you typically refer patients for services not provided in your clinic?

Appendix E: Map of Referral Patterns

